MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • Obstetrics

March 2006 • Bulletin 380

Contents

Xolair (Omalizumab) Injection Code Change and Dosage Correction

Effective April 1, 2006, providers must use HCPCS code J2357 when billing Xolair (omalizumab). Also, the *Injections* section of the Part 2 manual is updated to indicate the correct dosage for Xolair as 5 mg. *This information is reflected on manual replacement page inject 53 (Part 2).*

Enzyme Replacement Drugs Policy Update

Effective for dates of service on or after March 1, 2006, *Treatment Authorization Request* (TAR) requirements, billing codes and reimbursement rates for laronidase, alglucerase and agalsidase are updated to reflect the following:

Change From	Unit Dose	Change To	Unit Dose
Laronidase (C9209)	2.9 mg	Laronidase (J1931)	0.1 mg
Alglucerase (X7038)	80.0 u	Imiglucerase (J1785)	1.0 u
Alglucerase (J0205)	10.0 u		
Agalsidase (C9208)	1.0 mg	Agalsidase beta (J0180)	1.0 mg
Agalsidase (S0159)	35.0 mg		

Authorization requests for Medi-Cal recipients less than 21 years of age must be submitted to the California Children's Services (CCS) program. TARs for Medi-Cal recipients must be submitted to the Los Angeles Medi-Cal Medical (not Pharmacy) Field Office. Providers billing for recipients who are covered by both Medicare and Medi-Cal must bill Medicare first.

AUTHORIZATION REQUIREMENTS

The following specific clinical information is required when submitting a TAR for laronidase, imiglucerase or agalsidase beta:

Diagnosis and Age Requirements

When administering laronidase, a diagnosis of Mucopolysaccharidosis (ICD-9 diagnosis code 277.5) must be established. The recipient must be 5 years of age or older.

When administering imiglucerase, a diagnosis of Gaucher's disease (ICD-9 diagnosis code 272.7) must be established. There is no age requirement for the authorization of the use of imiglucerase.

When administering agalsidase beta, a diagnosis of Fabry's disease (ICD-9 diagnosis code 272.7) must be established. The recipient must be 16 years of age or older.

Please see **Enzyme Replacement**, *page 2*

Enzyme Replacement *(continued)*

Supporting Documentation
Supporting documentation for diagnosis and treatment of the established condition(s) must be submitted, including the following:

- Objective findings (exams, lab results)
  - Enzyme levels or other laboratory testing
  - DNA mutation analysis
  - Medical history
  - Physical examination
- Subjective findings (complaints, family history)
- Complications of disorder (for example, bony changes or kidney failure)
- Quality of life issues (for example, severe, unremitting pain or extreme fatigue)
- Identified caregiver (pediatric or internal medicine specialist) who can administer infusion therapy and coordinate care, and their:
  - Plan: Include the treatment plan and the genetic evaluation and counseling information for the recipient and family members
  - Goal: Include information about the desired outcome of the treatment plan; for example, to slow the progression of the disease, to allow regular attendance at work or school or to significantly improve the quality of life

Initial drug therapy will be approved as a three- or six-month trial, and a renewal TAR must include follow-up information. Follow-up documentation must note any significant changes in physical findings, laboratory parameters, symptoms and/or quality of life.

Special Instructions for Imiglucerase
Imiglucerase (HCPCS code J1785) is billed per unit, and dosage is based on the recipient's weight. Since the claim form cannot accommodate a four-digit number in the *Quantity* field, a separate authorization process is necessary.

The following are additional paper TAR instructions for imiglucerase:

- TAR submission and authorization requires the use of the negotiated rate process for reimbursement.
- Each administration of imiglucerase must be submitted on a separate TAR.
- The provider must document the patient's weight and the dosage of imiglucerase in the *Medical Justification* area of the TAR.
- In the *Specific Services Requested* area of the TAR, enter the number one (1) in the *Quantity* field.
- In the *Charges* field, enter the dollar amount of the usual and customary charge for the procedure.

Note: When submitting a claim for the reimbursement of imiglucerase, enter a one (1) in the *Days or Units* column on the *HCFA 1500* claim form.

Please see **Enzyme Replacement**, *page 3*

Enzyme Replacement *(continued)*

The following are additional instructions for imiglucerase when submitting an eTAR:

- To submit an eTAR, access the "TAR Services" window and click "Non-Pharmacy Issue Drug."
- In the "Other Services" window, enter a quantity of one (1) in the "Total Units" field, then complete all other applicable fields as appropriate, including the "Charges" field (enter the usual and customary charge).
- Access the "Enter Miscellaneous TAR Information" window and enter the recipient's weight and dosage of imiglucerase to be given.

This updated information is reflected on manual replacement pages inject 23, 55 and 56 (Part 2) and inject list 2, 4 and 9 (Part 2).

VFC Reminder that FluMist is Billed with a New Code Starting April

The November 2005 *Medi-Cal Update* announced that the administration fee for FluMist (influenza virus vaccine, live, for intranasal use) is a new benefit for the Vaccines For Children (VFC) program. The article indicated that the code to use for billing FluMist would change in 2006. The following chart summarizes the two codes and corresponding dates of service to use for billing FluMist.

Dates of Service	Bill With	CPT-4 Description
On November 1, 2005 through March 31, 2006	CPT-4 code 90749 and modifiers -SK (members of high-risk population) and -SL (state-supplied vaccine)	Unlisted vaccine/toxoid
On or after April 1, 2006	CPT-4 code 90660 and modifiers -SK and -SL	Influenza virus vaccine, live, for intranasal use

Dispensing Guidelines
FluMist is reimbursable only for healthy individuals 5 through 18 years of age who are close contacts of people with chronic health conditions.

Documentation for Patient's Record
Providers must note in the patient's record that the vaccine was administered to a healthy individual who is in close contact with a chronically ill individual and the reason the provider chose an intranasal preparation over an injectable vaccine.

Code 90749 Reminder
Providers were instructed that when billing for code 90749, they must document in the *Reserved For Local Use* field (Box 19), or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for FluMist.

Special timeliness overrides have been established for claims submitted with code 90749 for dates of service on or after November 1, 2005 through March 31, 2006.

Code 90660 information is reflected on manual replacement pages modif used 4 (Part 2) and vaccine 3 and 4 (Part 2).

End Stage Renal Disease Pilot Project

Under a four-year pilot project, recipients with End Stage Renal Disease (ESRD) may enroll in "VillageHealth operated by SCAN Health Plan" (VillageHealth), a Medicare Health Maintenance Organization (HMO). Effective for dates of service on or after January 1, 2006, VillageHealth serves recipients in select ZIP codes in San Bernardino and Riverside counties. Ordinarily, recipients with ESRD would be excluded from enrollment in a Medicare HMO.

VillageHealth is partnering with DaVita and other providers in this endeavor, as follows:

- VillageHealth (an ESRD Specialty Health Plan/California Medical Services Demonstration Project) is the primary payer
- DaVita renders the dialysis services
- Other providers may render additional medical services

Provider Manual
Policy about this pilot project has been added to the *MCP: Special Projects* section of the Part 1 Medi-Cal provider manual.

Billing
Providers bill for services to VillageHealth members as follows:

- Plan-covered services to VillageHealth
- Copayments, coinsurance or deductibles for plan-covered services to Medi-Cal (billed like a crossover claim)
- Services denied or not covered by VillageHealth, to Medi-Cal as standard fee-for-service claims

Copayments, Coinsurance and Deductibles
Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel instructions for billing Medicare/Medi-Cal hard copy crossover claims, except for the few additional requirements noted below. Therefore, billers should refer to the "Hardcopy Submission Requirements of Medicare-Approved Services" in the Part 2 manual.

In their interpretation of the manual, billers should consider "VillageHealth" the same as "Medicare." For example, in the *Medicare/Medi-Cal Crossover Claims: HCFA 1500* section, under the "Part B Services Billed to Part B Carriers" heading, the reference to "Medicare approved service" would also be interpreted as "VillageHealth approved service."

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national procedure codes and modifiers billed to VillageHealth and include the following:

- A copy of the *Remittance Advice* (RA) received from VillageHealth. The RA must state "SCAN ESRD PILOT" in the *Remarks* section at the bottom left and include the address and telephone number for VillageHealth in the upper right corner.
- VillageHealth AEVS (Automated Eligibility Verification System) carrier code "S323" in the *Insurance Plan Name or Program Name* field (Box 11c) on the *HCFA 1500.*

Electronic billing may eventually be an option.

This information is reflected on manual replacement pages mcp spec 7 and 8 (Part 1) and medicare 3 (Part 1).

New Dental Benefits for Certain Pregnant Women

On October 7, 2005, the Governor signed SB 377, which directed the California Department of Health Services (CDHS) to immediately provide coverage of certain non-emergency dental benefits, described below, for pregnant Medi-Cal recipients. These benefits were added because of recent scientific evidence showing an association between periodontal disease in pregnant women and adverse birth outcomes. These benefits may help prevent pre-term delivery and low birth weight; they are important for the health of both the mother and the newborn. If a pregnant recipient is not currently under the care of a dentist, providers are encouraged to refer her to one during her pregnancy.

Emergency dental procedures are already available to individuals. The procedures that have been added for pregnant women only are the following:

- Examination, initial episode of treatment only
- Evaluation, periodic
- Prophylaxis, beneficiaries through age 12
- Prophylaxis, beneficiaries age 13 years and older
- Prophylaxis, including topical application of fluoride, beneficiaries age 6 through 17
- Subgingival curettage and root planing per treatment
- Occlusal adjustment (limited) per quadrant (minor spot grinding)
- Gingivectomy or gingivoplasty per quadrant
- Osseus and mucogingival surgery per quadrant
- Gingivectomy, or gingivoplasty, treatment per tooth (fewer than six teeth)

If the recipient has questions about Denti-Cal, please refer her to the Denti-Cal Beneficiary Toll-Free Line: 1-800- 322-6384.

Pharmacy Minimum and Maximum Quantity Limits for Ortho Evra Patch

Effective retroactively for dates of service on or after March 24, 2005, the dispensing of Ortho Evra Patch contraceptives in pharmacies is limited to a minimum of one and a maximum of nine patches per recipient by any provider within a 90-day period. The billing of ten or more patches exceeds the 100-day supply restriction. Clinic dispensing of Ortho Evra Patch contraceptives (HCPCS code X7728) remains unchanged.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Provider Orientation and Update Session

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The remaining date for the first quarter of 2006 is listed below.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Please see **Provider Orientation**, *page 6*

Provider Orientation *(continued)*

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client-education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Session below.

March 20, 2006
California Department of
Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

For a map and directions to the CDHS Auditorium, go to the Family PACT Web site at **www.familypact.org** and click "map" under "Orientation Sessions."

Registration
To register for an Orientation and Update Session, go to the Family PACT Web site at **www.familypact.org**, click the appropriate date under "Orientation Sessions" and print a copy of the registration form. Fill out the form and fax it to the Office of Family Planning at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications.*

Addition, effective March 1, 2006

Drug	**Size and/or Strength**
DULOXETINE HCL	
Capsules	20 mg
	30 mg
	60 mg

Changes, effective February 18, 2006

Drug	**Size and/or Strength**
GLIMEPIRIDE	
Tablets	1 mg
	2 mg
	4 mg

~~(NDC labeler code 00039 [AVENTIS PHARMACEUTICALS] only.)~~

***** ZIDOVUDINE	
Tablets	300 mg
Capsules	100 mg
Liquid	50 mg/5cc
Injection	10 mg/cc

* Restricted to use as combination therapy in the treatment of Human Immunodeficiency Virus (HIV) infection.

(NDC labeler code 00173 [GlaxoSmithKline] for capsules, liquids, and injection only.)

Changes, effective March 1, 2006

Drug	**Size and/or Strength**
PAPAIN AND UREA	
Ointment	

(NDC labeler codes 00064 [Healthpoint, LTD], 59366 [Glades Pharmaceuticals], 50484 [Smith & Nephew, Inc.] **and 58980 [Stratus Pharmaceuticals]** only **until April 30, 2006**.)

(Effective May 1, 2006 NDC labeler codes 50484 [Smith & Nephew, Inc.] and 58980 [Stratus Pharmaceuticals] only.)

Please see **Contract Drugs**, *page 8*

Contract Drugs *(continued)*

Changes, effective March 1, 2006 (continued)

Drug	**Size and/or Strength**
PAPAIN-UREA-CHLOROPHYLLIN COPPER COMPLEX SODIUM	
Ointment	30 GM

(NDC labeler code 00064 [Healthpoint, Ltd.]**, 50484 [Smith & Nephew, Inc.], and 58980 [Stratus Pharmaceuticals]** only **until April 30, 2006**.)

(Effective May 1, 2006 NDC labeler codes 50484 [Smith & Nephew, Inc.] and 58980 [Stratus Pharmaceuticals] only.)

***** Spray	33 cc

*** Prior authorization always required.**

Instructions for Manual Replacement Pages — Part 2

March 2006

Obstetrics Bulletin 380

Remove and replace:	inject 23 thru 26
Remove:	inject 53/54
Insert:	inject 53 thru 57
Remove and replace:	inject list 1 thru 4, 9/10 modif used 3/4 vaccine 3/4